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Office of Administrative Law Judges
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Issue Date: 12 January 2006

Case No. 2002-BLA-0354

In the Matter of:
EDWARD E. DOBRZYNSKI,
Claimant,

v.

VALLEY CAMP COAL CO.,
c/o ACCORDIA EMPLOYERS SERV.
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party in interest .

APPEARANCES:
Christopher R. McFadden, Esq.
On behalf of Claimant

William S. Mattingly, Esq.
On behalf of Employer

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On June 5, 2002, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 28).[2] A formal hearing on this matter was conducted on January 29, 2004, in Cincinnati, Ohio by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations;

3. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether the Claimant's disability is due to pneumoconiosis; and

5. Whether the Claimant has established a material change in conditions under §725.309(c), (d).

(DX 28).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Edward Dobrznski ("Claimant") was born on July 2, 1937; he was 66 years old at the time of the hearing. (DX 1; Tr. 26). Since the hearing, I have been notified that Mr. Dobrznski passed away in January 2005.

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing, Employer withdrew as uncontested the following issues: whether Claimant was a miner; whether miner worked as a miner after December 31, 1969; whether miner worked at least 13 years in or around one or more coal mines; whether the miner is totally disabled; whether Claimant has one dependent for purposes of augmentation; whether the named employer is the responsible operator; and whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator. (Tr. 21-23). Also, while Employer marked that it continued to contest refiled claim and modification, since this claim was filed more than one year after the previous denial, I find that this is a refiled claim.

Claimant was previously married to Mildred Varner, but they divorced in September 1952. (DX 1). He stated that he is not currently under a court order to make support payments and does not make substantial contributions to Ms. Varner. (DX 1). On January 31, 1964, Claimant married Shirley Newland, and they remain married and living together. (DX 1, 4; Tr. 26-27). Claimant does not have any dependent children. (DX 1). I find that Claimant has one dependent for purposes of augmentation.

On his application for benefits, Claimant stated that he engaged in coal mine employment for 14 years. (DX 1). From 1966 until 1974, Claimant performed a variety of underground mining jobs. (EX 10). Claimant's last coal mine employment, from 1974 until 1980, was working above ground in the control room at the tipple. (Tr. 28; EX 10). While this job generally involved sweeping, Claimant testified that he was also required to repair belts, shovel coal, and climb 30 feet of stairs on a regular basis. (Tr. 28-33). Claimant stated that he last worked in and around coal mines in 1980, but quit when the mine closed. (DX 1). Claimant noted that he received a $10,000 award for his West Virginia State pneumoconiosis claim. (DX 1, 3; Tr. 48).

Procedural History

Claimant filed his first claim for benefits on May 14, 1982. (DX 26). This claim was ultimately denied by the District Director, Office of Workers' Compensation on October 8, 1982. Claimant did not appeal this claim.

Claimant filed his second claim for benefits under the Act on April 13, 1999. (DX 27). The Director issued an initial denial on September 15, 1999, finding that Claimant had not satisfied any of the elements of entitlement. On October 29, 1999, the Director issued a notice that Claimant had not filed any appeal, and noted that Claimant could request modification until September 14, 2000.

Claimant filed the instant application for benefits on November 2, 2000. (DX 1). On May 9, 2002, the Director issued an initial determination awarding benefits. (DX 22). Employer appealed on May 15, 2002, (DX 23), and the matter was transferred to the Offices of Administrative Law Judges on June 5, 2002 for a formal hearing. (DX 28).

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier.

At the hearing, Claimant stated that he never been told by a doctor that he was totally disabled due to black lung disease of coal workers' pneumoconiosis. (Tr. 48). As a result, I find that the requirements of § 725.308(a) are not satisfied and a three year limitation period as

not commenced. Therefore, I find that Mr. Dobrzynski's claim is timely pursuant to the presumption found at § 725.308(c).[4]

Length of Coal Mine Employment

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations. On his application for benefits, Claimant stated that he engaged in coal mine employment for 14 years. (DX 1). The parties have stipulated to at least 13 years of coal mine employment. (DX 28; 21-22). A review of the record supports this stipulation.(DX 26-27; Tr. 27). Therefore, I find that Claimant engaged in qualifying coal mine employment for at least 13 years.

Claimant's last employment was in the State of West Virginia (DX 2; Tr. 27); therefore, the law of the Fourth Circuit is controlling. [5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Valley Camp Coal Co. as the putative responsible operator. Valley Camp Coal Co. does not contest this issue. (DX 28; Tr. 22). Therefore, after review of the record, I find that Valley Camp Coal Co. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 26	6/18/82	6/18/82	Barger, BCR[6], B-reader[7]	Negative
DX 26	6/18/82	7/16/82	Cole, BCR, B-reader	Negative
DX 20	1/19/99	3/01/02	Meyer, BCR, B-reader	Negative
EX 1	1/19/99	8/27/02	Fino, B-reader	Negative
EX 8	1/19/99	12/9/02	Branscomb	Negative

[4] At the hearing, Employer maintained its contention that this claim was not timely. However, in its post-hearing brief, Employer conceded this issue. ER. Br. at n.3

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

[6] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[7] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

DX 27	5/21/99	9/02/99	Sargent, BCR, B-reader	Negative
DX 17	5/21/99	3/14/01	Wiot, BCR, B-reader	Negative
DX 17	5/21/99	5/26/01	Morgan, B-reader	0/1 tt
CX 6	1/05/01	1/05/01	Ahmed, BCR, B-reader	1/1 tu
DX 9	1/05/01	4/24/01	Gazino, B-reader	1/0 tt
CX 2	1/05/01	1/05/04	Cohen, B-reader	1/0 qt
CX 7	1/05/01	1/12/04	Miller, BCR, B-reader	1/1 tu
CX 3	5/28/03	1/05/04	Cohen, B-reader	1/0 qt
EX 12	5/28/03	2/24/04	Wiot, BCR, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**[8]	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 26 6/18/82	Good/ Good/ Yes	44 69”	3.25	5.06	96	64	No
DX 27 9/28/98	None Listed/ None Listed/ No	61	**1.17**	2.71		**43**	**Yes**[9]
DX 21 5/21/99	Good/ Good/ Yes	61 67”	**1.26** **1.6***	3.21 4.16*	**44.68** **68.42***	**39** **38***	**Yes**[10] **Yes**
DX 17 9/9/99	None Listed/ None Listed/ No	62 69”	**.88**	**2.21**		**40**	**Yes**[11]
DX 17 10/18/99	None Listed/ None Listed/ Yes	62 69”	**1.2**	2.7		**44**	**Yes**[12]
DX 5 1/5/01	Adequate Effort Yes	63 67.5”	**.66** **.89***	**1.79** 2.40*	**35** **47***	**37** **37***	**Yes**[13] **Yes**

* indicates post-bronchodilator values

[8] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). Therefore, I find that the miner’s actual height is 68 inches.

[9] Dr. Ben Branscomb, an internist, invalidated this study due to a lack of tracings. (EX 8)

[10] Dr. Richard Katzman, an internist and pulmonologist, determined that the vents were acceptable. (DX 27). Dr. Branscomb, however, invalidated this study due to the lack of confirming curves. (EX 8, 14:49).

[11] Dr. Branscomb invalidated this study due to a lack of confirming checks. (EX 8).

[12] Dr. Branscomb invalidated this study because there were only two curves, one of which showed Claimant holding his breath. (EX 8).

[13] Dr. Cohen stated that cooperation and understanding were adequate and the tracings were reproducible and show good effort. (CX 1). Dr. Branscomb, however, invalidated this study due to the existence of only one curve for the pre-bronchodilator and one curve for the post-bronchodilator studies. (EX 8, 14:49).

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_{2*}	pO_{2*}	Qualifying
DX 26	6/18/82	41.5 43.3*	89.9 97.6*	No No*
DX 27	5/21/99	37 35*	69 63*	No[14] Yes
DX 7	1/5/01	38 40*	68 55*	No[15] Yes

*indicates post-exercise values

Narrative Reports

Dr. R. Frome examined the Claimant on June 18, 1982. (DX 26). Dr. Frome considered the following: symptomatology (cough, sputum, wheezing, and dyspnea), employment history (16 years coal mine employment working as a buggy operator, shot fire, bolter, and at the tipple), individual history (no relevant history), family history (cancer, emphysema, and stroke), smoking history (¾ packs per day for 20 years), physical examination (no significant findings), chest x-ray (0/0), PFT (non-qualifying), ABG (non-qualifying), and an EKG. Dr. Frome diagnosed chronic bronchitis by history, but found no evidence of pneumoconiosis. He also noted that coal dust exposure would contribute to and aggravate Claimant's chronic bronchitis. While Dr. Frome did not specifically note Claimant's level of pulmonary disability, he did identify the following pulmonary limitations: climbing one to two flights of stairs; lifting 40 to 50 lbs without difficulty; carrying 50 lbs a distance of 50 to 100 feet; and no significant walking limitations.

Dr. Mark Farber examined the Claimant on July 21, 1999. (DX 27). Dr. Farber considered the following: symptomatology (sputum, wheezing, dyspnea, cough, chest pain, and inability to do any activity requiring exertion), employment history (14 years coal mine employment, 8 of which were outside working at the tipple), individual history (pneumonia, attacks of wheezing, arthritis, and heart disease), family history (cancer and stroke), smoking history (discontinued habit of 36 to 38 years at a rate of one pack per day), physical examination (occasional wheeze bilaterally), chest x-ray (0/0), PFT (severe airflow obstruction with significant response to acute bronchodilator inhalation revealing reversible airway obstruction), and an ABG (mild hypoxia). Based on smoking history and physical findings, Dr. Farber diagnosed COPD caused by smoking and coal dust exposure. He also diagnosed IPF[16] and CAD. Dr. Farber opined that Claimant's resultant impairment was severe, rendering him 100% disabled and unable to perform little if any work.

[14] Dr. Richard Katzman determined that this ABG was technically acceptable. (DX 8). Dr. Cohen noted, however, that this study was sub-maximal with the patient achieving only 72% of his age predicted maximum heart rate. (CX 1).

[15] Dr. Richard Katzman determined that this ABG was technically acceptable. (DX 8).

[16] As noted by Dr. Branscomb, (EX 14:114), there is some question as to whether Dr. Farber diagnosed idiopathic pulmonary fibrosis, which is unrelated to coal mining, or interstitial pulmonary fibrosis, which can be the result of coal mine employment.

Dr. Farber also examined the Claimant on October 26, 2001. (DX 6, 5). Dr. Farber considered the following: symptomatology (sputum, wheezing, dyspnea, cough, and chest pain), employment history (14 years coal mine employment), individual history (pneumonia, attacks of wheezing, arthritis, and heart disease), family history (cancer and stroke), smoking history (smoked one pack per day from approximately age 13 to age 50, or 35 pack-years), physical examination (occasional bilateral wheeze on auscultation, and some resonance), PFT (significant response to acute bronchodilator inhalation that indicates partially or completely reversible airway obstruction; the combined decrease in expiratory flow and the decrease FVC and FEV1 are suggestive of a combined restrictive and obstructive abnormality; the severity of obstruction is difficult to assess in the presence of a possible restrictive ventilatory abnormality), and an ABG (mild hypoxemia; moderately hypoxemic with exercise). Dr. Farber diagnosed COPD and IPF caused by smoking and coal dust exposure. He opined that Claimant's severe impairment resulted in a 100% pulmonary disability that prevented him from performing any kind of work.

Dr. Mason Goodman, an internist and pulmonologist, examined Claimant and submitted a report dated October 26, 1999. (DX 17). Dr. Goodman considered the following: symptomatology (shortness of breath and dyspnea on exertion), employment history (14 years coal mine employment, last working outside the mine in the operation control booth doing a variety of jobs), individual history (hospitalized twice for pneumonia, previously received 15 % West Virginia Black Lung disability, and heart problems), smoking history (smoked 1 ½ packs per day from age 16 until age 50 for a cumulative total of 70 pack-years), physical examination (increased AP diameter with some flattening of the diaphragms by motion detection; breathing sounds are somewhat diminished), PFT (essentially the same as previously noted), and an ABG (no values listed, but a notation that with exercise, patient did fall to 90%). Dr. Goodman also reviewed Dr. Pike's records, including those related to hospitalization at Westview. Dr. Goodman stated that the marked change in Claimant's exercise capacity – given the fact that his oxygen saturation at rest was not materially different than two years prior and his lung function measurement was roughly the same – made it hard to guess that Claimant has multiple diseases. He also stated that based on exposure to coal dust, Claimant "certainly qualifies for his prior diagnosis of black lung." Dr. Goodman also said, "No doubt, he also has underlying chronic obstructive lung disease and chronic bronchitis as evidenced by his past smoking history even though he has not smoked over the last 12 years." Despite these pulmonary diagnoses, Dr. Goodman concluded that it was not clear whether Claimant's shortness of breath was due to the lung disease, the result of his cardiac situation, or a combination of both.

Dr. Goodman was deposed by the Employer on March 11, 2002. (DX 21). Prior to the deposition, Dr. Goodman reviewed the chest x-ray dated January 19, 1999 and a CT scan dated April 29, 1999. Dr. Goodman noted that the x-ray showed changes of hyperinflation consistent with COPD, and also showed some mild increase in interstitial changes and some calcified granulomatous changes. The CT scan revealed that the interstitial changes were much less prominent, and most of it was consistent with centrilobular emphysema. Also, the calcified granuloma showed up very well with a very high Hounsfield number suggesting calcification. Dr. Goodman stated that he did not see any changes suggestive of small rounded opacities or nodules of CWP on either the CT scan or the chest x-ray, and explained that it is very difficult to diagnose CWP with essentially no data on a CT scan or a chest x-ray. Next, Dr. Goodman considered a May 21, 1999 PFT, and noted that Claimant's post-bronchodilator improvement in

vital capacity and forced expiratory volume is certainly compatible with reversible airways disease associated with severe obstructive disease.

Dr. Goodman's deposition consisted mostly of a restatement of the findings of his earlier written report. He further opined that severe COPD with centrilobular emphysema are almost always a consequence of cigarette smoking. Concerning his prior finding – Claimant had an exposure to coal mine dust and qualified for the prior diagnosis of black lung disease – Dr. Goodman clarified that he did not find any evidence of CWP considering the CT scans, x-rays or physical examination. Dr. Goodman further stated that there was nothing in Claimant's presentation, his symptoms, or his ventilatory studies that would be inconsistent with COPD caused by cigarette smoking alone.

Dr. W. K. C. Morgan, a B-reader, submitted a consultation report dated January 6, 2002. (DX 18). Dr. Morgan considered the following relevant evidence: his own May 28, 2001 report; Claimant's application for benefits and coal mine employment summary; Dr. Frome's June 18, 1982 examination report; PFT and ABG studies dated June 18, 1982; Dr. Bargar's interpretation of the June 18, 1982 chest x-ray; Dr. Scales' interpretation of the September 1, 1998 chest x-ray; Dr. Pike's September 28, 1998 report of occupational pneumoconiosis for the West Virginia Workers' Compensation Fund; Dr. Pike's September 28, 1998 report addressed to Mr. Nelligan; Dr. Gokhale's interpretation of the January 19, 1999 chest x-ray; Dr. Sheperd's April 29, 1999 CT scan report; Dr. Pike's May 4, 1999 consultation report; Dr. Farber's May 21, 1999 examination report including PFT and ABG values; Dr. Skiles' interpretation of the May 21, 1999 x-ray; Dr. Pike's consultation report dated September 9, 1999; Dr. Goodman's October 18, 1999 pulmonary consultation; Dr. Meyer's and Dr. Gaziano's interpretations of the January 5, 2001 x-ray; and Dr. Farber's October 26, 2001 examination report. Dr. Morgan began his summary by discrediting Claimant's reports of coal mine employment, stating that he was deceptive in his reports of 14 years of employment. Dr. Morgan opined that because Claimant only worked for eight years underground, and not entirely at the face, it was very unlikely that he would develop CWP. Dr. Morgan next attacked Claimant's smoking admissions accusing him of being "economical with the truth."

Turning to the objective evidence, Dr. Morgan noted that most x-ray interpretations stated that there was no CWP present, and some who previously found CWP changed their minds. In addition, the CT scan evidence was negative. Considering the lung function testing, Dr. Morgan opined that there was no doubt that Claimant has severe airways obstruction, but there is no evidence of any restrictive impairment. He explained that those who diagnosed a restrictive impairment failed to note that the FVC maneuver was not sustained for a sufficiently long interval. Since Claimant's FEV1 has continued to decline since his retirement, and considering the absence of silicosis, Dr. Morgan explained that the decrease was due to cigarette smoking. Dr. Morgan ultimately concluded that based on the negative x-rays and limited exposure to coal mine dust, that there was insufficient evidence to justify a diagnosis of CWP. Also, while Claimant was completely incapable of working in the coal mines or in any other job due to his severe airways obstruction, Dr. Morgan concluded that this condition was entirely due to cigarette smoking.

Dr. Morgan was deposed by the Employer on March 14, 2002 when he repeated the findings of his earlier written report. (DX 21). In addition, Dr. Morgan also reviewed the January 19, 1999 chest x-ray and the April 29, 1999 CT scans. Dr. Morgan opined that the x-ray evidence of record revealed emphysema and "t" opacities frequently seen in patients who have asbestosis or other occupationally related lung disease, but that these types of opacities are not seen in silicosis or CWP. He also opined that the CT scan evidence revealed emphysema in the upper and mid zones and some in the lower zones with a few calcified granulomata, but he found absolutely no evidence of nodules compatible with CWP. Turning to Claimant's pulmonary capacity, Dr. Morgan confirmed Dr. Farber's diagnosis of COPD, but disagreed with his identification of idiopathic pulmonary fibrosis. Dr. Morgan provided a detailed explanation as to how the pulmonary function testing conducted in 1982, when compared to that conducted in the late 1990's, and considered in conjunction with the x-ray and CT scan evidence, revealed a pulmonary regression consistent with emphysema and COPD caused by cigarette smoking. He added that there was nothing unusual about the pattern of impairment that would lead him to believe that Claimant's totally disabling impairment was the result of anything other than cigarette smoking. Finally, Dr. Morgan stated that even if CWP was identified by autopsy or biopsy, the minimal amount of CPW would not affect Claimant's lung function in any manner, shape or form.

Dr. Christopher Meyer, a radiologist and B-reader, interpreted the April 29, 1999 CT scan, and submitted a report on March 1, 2002. (EX 5; DX 20). He opined that while there was evidence of moderate to severe centrilobular emphysema, and sequellae of prior granulomatous disease, there was no CT scan evidence of CWP.

Dr. Meyer submitted an interpretation of the February 28, 2002 CT scan on October 9, 2002. (DX 4, 6). He found the study to demonstrate moderate to severe bilateral emphysema. He also identified scattered, irregular large nodular opacities in the mid lung zones bilaterally, many of which demonstrated dense calcification. Next, he identified the more irregular focal area of the somewhat angular opacity in the anterior segment of the left upper lobe with linear density extending to the pleural. Dr. Meyer opined that these results were most consistent with post-inflammatory scaring. He also noted no centrilobular opacities, no fine nodular opacities, and no perilymphatic nodularity. Based on these readings, Dr. Meyer concluded that there was no evidence of CWP, but that Claimant suffered from moderate to severe bilateral emphysema. In addition, he opined that absent any centrilobular fine nodularity, the large scattered nodules were inconsistent with CWP and are more likely sequellae of prior granulomatous disease.

Dr. Meyer was deposed by the Employer on October 30, 2002, when he repeated the findings of his earlier written report. (EX 7). He added that that his 1999 CT scan findings were consistent with his interpretation of the January 19, 1999 chest x-ray, and while the 1999 CT scan was not a high-resolution, it was adequate for purposes of diagnosis. Dr. Meyer also noted that while the 2002 CT scan was not a high resolution quality scan, it was "pretty close." Finally, based on both of these CT scans and the x-ray evidence he considered, Dr. Meyer opined that there was nothing to suggest changes consistent with CWP or any other coal mine dust induced pneumoconiosis.

Dr. Gregory Fino, an internist, pulmonologist, and B-reader, submitted a consultative report on August 27, 2002. (EX 1-2). Dr. Fino considered the following medical evidence from the record: Dr. Frome's June 18, 1982 examination report; Drs. Scales and Pike's interpretations of the September 1, 1998 x-ray; Dr. Pike's September 28, 1998 examination report; Drs. Meyer, Gokhale, and Fino's interpretations of the January 19, 1999 chest x-ray; the April 29, 1999 CT scan report; Dr. Pike's May 4, 1999 examination report; the May 21, 1999 examination report; Dr. Pike's September 9, 1999 examination report; Dr. Goodman's October 18, 1999 examination report; the January 5, 2001 PFT, ABG and x-ray readings; the October 26, 2001 examination report; Dr. Morgan's January 6, 2002 medical evidence review; and the February 28, 2002 CT scan report. Dr. Fino also interpreted the January 19, 1999 chest x-ray and the (0/0), and the April 29, 1999 CT scan (negative for CWP).

Dr. Fino noted that Claimant had stopped working in the mines in 1980, and that his 1982 pulmonary testing revealed no evidence whatsoever of any ventilatory impairment or oxygen transfer abnormality. Claimant, however, continued to smoke until the mid-1980s, and by the time of his next pulmonary testing in 1998, his FEV1 had decreased 2 liters. Dr. Fino opined that this sort of dramatic drop is not consistent with a coal mine dust related pulmonary condition, but is consistent with smoking. Also, Claimant's ABG at rest and with exercise had gone from normal in 1982, to values reflecting significant resting hypoxemia with worsening of oxygen levels with exercise. As a result, Dr. Fino concluded that while Claimant had a disabling respiratory impairment due to smoking, there was insufficient medical evidence to justify a diagnosis of clinical or legal pneumoconiosis, and thus, coal dust inhalation played absolutely no role in his pulmonary disability. He added that even if he were to assume Claimant had clinical or legal pneumoconiosis, he would still find that those diseases had not contributed to his disability.

Dr. Fino submitted an interpretation of the February 28, 2002 CT scan on September 23, 2002. (DX 3). He found the study to include no pleural and no parenchymal abnormalities consistent with simple or complicated pneumoconiosis. And while he identified an area of infiltrate with questionable bronchiectasis in the upper left lobe, he dismissed these as possible pneumonia or granulomatous disease, and opined that there were no changes consistent with pneumoconiosis.

Dr. Ben Branscomb, an internist, submitted a medical evidence review on December 9, 2002. (EX 8-9). Dr. Branscomb considered the following records: Dr. Frome's June 18, 1982 report; Dr. Pike's September 28, 1998, May 4, 1999, May 21, 1999, and September 9, 1999 medical reports; Dr. Goodman's October 18, 1999 medical report; Dr. Farber's January 5, 2001 and October 26, 2001 reports; Dr. Morgan's January 6, 2002 report; Dr. Fino's August 27, 2002 report, and Dr. Meyer's October 30, 2002 B-reader deposition. Dr. Branscomb also based his opinion on 14 years of coal mine employment, including eight years underground at the face, and six years above ground. Concerning smoking, while Dr. Branscomb noted varying reports over the years, he specifically documented Dr. Goodman's 70 pack-year finding. He also noted that Claimant's carboxyhemoglobin levels revealed that he no longer smokes.

Dr. Branscomb reviewed the objective test results of record. Based on x-ray interpretations of the June 18, 1982, September 1, 1998, January 19, 1999, May 21, 1999, and

January 5, 2001 films; the January 19, 1999, January 26, 1999, April 29, 1999, and February 28, 2002 CT scans; his own negative interpretations of the February 28, 2002 and April 29, 1999 CT scans; and his own interpretation of the January 19, 1999 chest x-ray, Dr. Branscomb concluded that he agreed with Dr. Meyer's findings, and that the x-ray interpretations do not support a diagnosis of CWP. Next, Dr. Branscomb stated that all of the PFTs of record were invalid. He also found that with exception of the January 5, 2001 ABG, which showed hypoxemia with exercise, all of the blood gas evidence was normal. In conclusion, considering the contours of the available curves combined with the blood gas values, he opined that Claimant suffered from severe, partly reversible, obstructive airways disease, which had worsened since 1999.

Dr. Branscomb summarized his findings by stating that he found insufficient objective evidence to justify a finding of CWP. He characterized Claimant's obstructive pulmonary disease as that typical of the COPD found in patients with severe smoking habits, especially those who have GERD. He further noted that Claimant's exposure to coal dust was light, and explained that the sequence of Claimant's retirement in 1980, in conjunction with his worsening pulmonary condition, is not consistent with obstruction secondary to coal dust exposure, but is characteristic of cigarette smoking. Dr. Branscomb also opined that Claimant is totally disabled as the result of his pulmonary impairment and unable to perform his previous coal mine work, but he reiterated that this impairment was the result of cigarette smoking and GERD, and was in no way caused by or aggravated in whole or in part by coal dust or pneumoconiosis. Finally, Dr. Branscomb noted that his opinion as to the cause of Claimant's total disability would remain unchanged even if he had found that Mr. Dobrzynski suffered from pneumoconiosis.

Dr. Branscomb submitted a supplemental medical evidence review dated February 6, 2004. (EX 11). Considering Dr. Cohen's January 5, 2004 evidence review, Dr. Branscomb disagreed with Dr. Cohen's opinion as to the validity of some of the PFTs, and admitted that Dr. Cohen had accurately noted that Dr. Branscomb had failed to consider the normal 1982 PFT. Dr. Branscomb, however, rejected Dr. Cohen's conclusion that a 40 to 52-year pack-year history would be unlikely to cause the FEV1 variance seen between the 1982 and 1999 PFTs, and described in detail his reasons for his rejection of this opinion. Turning to Dr. Diaz's January 7, 2004 report, Dr. Branscomb noted that Dr. Diaz's criticism of his report was unjustified, because Dr. Branscomb did not, in fact, base his opinion on a 70 pack year history. Instead, Dr. Branscomb noted that the record includes histories ranging from 40 to 50 pack-years, which is twice the amount of tobacco exposure ordinarily associated with a high likelihood of severe progressive COPD. He also disagreed with Dr. Diaz's characterization of a 34 to 51 pack-year smoking history as "moderate." Dr. Branscomb concluded that despite these additional reports, his opinions concerning Claimant's pulmonary condition remained unchanged.

Dr. Branscomb was deposed by the Employer on March 15, 2004, when he repeated the findings of his earlier written report. (EX 14). Dr. Branscomb also clarified that his opinions were based on a 35 to 50 pack-year smoking history. (EX 14: 22-23). In addition, due to the invalidity of the PFTs of record, Dr. Branscomb admitted that he was unable to conclude, with reasonable certainty or probability, that Claimant was unable to perform the exertion or rigors of his last coal mine employment from a pulmonary standpoint. (EX 14: 66-68). Dr. Branscomb was also cross-examined at length, and while there were some questions specific to Claimant's condition, a majority of the questions focused on hypothetical scenarios and speculation

designed to undermine his opinion. He was further cross-examined on his familiarity with the medical literature Dr. Cohen considered as the basis of his report, but on re-direct Dr. Branscomb explained that none of the articles Dr. Cohen considered describe anyone that resembles the degree of impairment suffered by Claimant. (EX 14: 166). Finally, a good portion of Claimant's cross-examination and re-cross focused on repeated requests for Dr. Branscomb to recite from memory all of the articles from the medical literature that had contributed to the development of his opinions.

Dr. Robert Cohen, an internist, pulmonologist, and B-reader, submitted a medical evidence review dated January 5, 2004. (CX 1). Dr. Cohen considered the following: employment history (12 years of actual coal mine employment, eight of which was underground as a general laborer and the last four above ground at the tipple performing utility work), smoking history (34 years at a rate if 1 to 1 ½ packs per day, quitting in 1987, or 35 to 53 pack-years), chest x-ray (he independently read the 5/28/03 and 1/5/01 films as 1/0 qt), and a CT scan (2/28/02 study shows round irregular opacities, predominant in the upper lobes of 1.5 to 3 mm in diameter; there are also large opacities present, with one in the left upper lobe which is polygonal in shape and measures 2 cm X 1 cm X 1.8 cm, and another in the right upper lobe that is 1 cm X .5 cm, and a third round calcified opacity in the right lower lobe superior segment; there are also diffuse changes of emphysema present in both lungs). Dr. Cohen also considered the following medical evidence from the record: Dr. Farber's October 26, 2001 examination report; Dr. Frome's June 18, 1982 examination report; Dr. Goodman's October 18, 1999 examination report; Dr. Pike's September 9, 1999 examination report; Dr. Branscomb's December 9, 2002 consultation report; Dr. Fino's August 27, 2002 consultation report; Dr. Morgan's January 6, 2002 consultation report; the January 5, 2001, October 18, 1999, May 21, 1999, and June 18, 1982 PFTs; the January 5, 2001, May 21, 1999, and June 18, 1982 ABG studies; x-ray interpretations of the May 28, 2003, January 5, 2001, May 21, 1999, April 29, 1999, January 19, 1999, September 1, 1998, and June 18, 1982 films; five interpretations of the February 28, 2002 CT scan; and Dr. Shepherd's interpretation of the April 29, 1999 CT scan.

Based on this evidence, Dr. Cohen diagnosed clinical and legal pneumoconiosis that he found to be substantially related to coal mine employment. Concerning clinical pneumoconiosis, Dr. Cohen cited several positive x-ray and CT scan interpretations. He also noted that the opacities in the right and left upper lobes may represent complicated pneumoconiosis. However, he explained that even if the x-ray evidence in its entirety was determined to be negative, his opinion as to the existence of legal pneumoconiosis would remain unchanged. Turning to legal pneumoconiosis, Dr. Cohen opined that it is very unlikely that the reduction in PFT values between 1982 and 1999, 12 years after Claimant quit smoking and 17 years after he retired from coal mine employment, was caused by the seven years of continued smoking alone. Also, he found that the overall PFTs demonstrated a progressively severe obstructive defect caused by coal dust and smoking that most likely was present in 1982 based on the FEV1 that was at the lower limit of normal, and then progressed over the next 20 years. Beginning in 1999, the ABG studies, he concluded, showed significant gas exchange abnormalities which were due more to coal dust exposure than tobacco smoke. Dr. Cohen also provided an extensive medical literature review to support these conclusions.

Dr. Cohen next opined that Claimant has had a clear progression of his pulmonary disease since 1999, with a decline in FEV1 from 48% of predicted in 1999 to 19% of predicted in 2001, and a worsening of his arterial oxygen level with exercise from 63 mmhg in 1999 to 55 mmhg in 2001. Considering the requirement of the cleaning plant operator position, Dr. Cohen concluded that based on the most recent FEV1 and the significant gas exchange abnormalities with exercise, Claimant was unable to perform his previous job or any gainful work.

Dr. Cohen also provided a commentary on the reports by Drs. Branscomb, Fino, and Morgan. He explained that Dr. Branscomb relied on a combination of circumstances to rule out coal dust exposure as a cause of COPD, including the progression of exercise induced hypoxemia 19 years after leaving the mines. Dr. Cohen pointed out that Dr. Branscomb had failed to mention that this reduction took place 12 years after Claimant quit smoking. He also noted that Dr. Fino's and Dr. Morgan's opinions were based on a belief that disease caused by coal dust cannot progress, and thus had to be caused by tobacco smoke exposure. Dr. Cohen opined that these physicians' analyses were wrong, and citing the medical literature, he emphasized that disease caused by coal dust exposure can progress even after exposure ceases.

Claimant testified at the hearing that Dr. Ian G. Dowdeswell had treated him for a couple of years. (Tr. 46). Dr. Dowdeswell clarified in his January 6, 2004 letter by stating that he had treated Mr. Dobrzynski since January 2001. (CX 5). Dr. Dowdeswell noted that the record included an extensive smoking and coal mine history. Dr. Dowdeswell stated that Claimant's January 2, 2004 PFT showed very severe airflow obstruction with some response to bronchodilators, and that he had conducted seven PFTs over the previous three years, and that the 2004 chest x-ray showed hyperinflated lungs with small nodular opacities in the upper zones compatible with inorganic dust exposure. Based on these findings, Dr. Dowdeswell opined that Claimant suffers from severe obstructive lung disease caused by both cigarette smoking and CWP, and that his disease precludes him from gainful employment in any position other than an entirely sedentary one. He further explained that the x-ray abnormalities, PFT results, and the well-recognized association between coal dust exposure and obstructive lung disease makes it "likely" that Claimant's occupational exposure contributed to his progressive lung disease and debility.

Dr. Philip Diaz, an internist and pulmonologist, submitted a letter on January 7, 2004. (CX 4). While Dr. Diaz did not list all of the evidence he considered in reaching his conclusions, he did specifically note a review of the January 5, 2001 PFT, Dr. Fino's August 2002 report, and Dr. Morgan's January 2002 report, Dr. Goodman's October 1999 report, and Dr. Branscomb's December 2002 report. Based on these records, Dr. Diaz opined that Claimant is permanently disabled secondary to severe COPD in the form of emphysema, which has resulted in severe dyspnea and chronic cough. He also opined that these conditions are the result of combined coal dust exposure and cigarette smoking. In support, Dr. Diaz first noted that Dr. Goodman miscalculated Claimant's pack-years at 70, and that Dr. Branscomb seized on this overrepresentation to characterize Claimant as a heavy smoker. Dr. Diaz, however, explained that the accurate 34 to 51 pack-year history qualified Claimant as a "moderate" smoker. He opined that considering Claimant's very severe airflow obstruction in the setting of a moderate smoking history, coal dust exposure was a factor in the development of Claimant's lung disease. Contrary to the opinions of Drs. Branscomb, Fino, and Morgan, Dr. Diaz does not feel that the

progression of emphysema after removal from coal mines rules out coal dust as a contributing cause. He explained:

> In fact, it is not uncommon for emphysema to progress after removal of the causative exposure, whatever that may be. Indeed, emphysema related to cigarette smoke, or resulting from injection drug use can lead to disabling dyspnea decades after the exposure has stopped. Similarly, it would not be surprising for emphysema secondary to the combined effects of coal dust and cigarette smoke to progress, even after an individual leaves the mines. Furthermore, existing studies linking coal dust exposure to chronic obstructive pulmonary disease do not suggest that progression of disease after leaving the coal mines rules out coal dust as a contributing cause of the airflow limitation.

I note that in comparing the exertional requirements with Claimant's pulmonary impairment, Dr. Diaz discussed an accurate coal mine employment history.

Treatment Records

The record includes a variety of treatment records spanning from 1998 through 2002. The relevant records are summarized as follows:

September 1, 1998 – X-ray report by Dr. Scales: Changes of COPD are seen with parenchymal scarring bilaterally. Tiny calcified interstitial nodules are noted bilaterally. No definite pulmonary masses are seen and no active infiltrates are identified. Impression: COPD. (DX 17).

September 28, 1998 – Medical summary letter from Dr. Pike[17] - symptomatology (shortness of breath, intolerance to exertional activities, wheezing, cough, and sputum), employment history (14 years coal mine employment), individual history (elements of bronchitis and emphysema, hospitalization for pneumonia in 1993, and previously diagnosed occupational pneumoconiosis), family history (stroke and cancer), smoking history (30 years at a rate of 1 to 1 ½ pack per day, quitting 12 years ago), physical examination (increased fixed expansion with poor inspiratory expansion otherwise; increased resonance to percussion; diminished breath sounds in both lungs posteriorly; documented bibasilar crackles mid-lung to lower lung regions; anterior chest is essentially clear to auscultation), chest x-ray (8/98 x-ray showing evidence of scarring in the mid-upper lung regions bilaterally; a 1 cm area in the right mid-lung likely to reflect old granulomatous disease or nodular scarring; subsequent film showed flattening of the diaphragms consistent with underlying emphysema), PFT (severe obstructive ventilatory defect), and an ABG. Based on the x-ray evidence and history of coal mine employment, Dr. Pike affirmed the previous diagnosis of pneumoconiosis. He also diagnosed COPD with elements suggestive of both emphysema and chronic bronchitis based on the PFT revealing severe obstructive ventilatory defect. He further noted that the x-ray showed probable old granulomatous disease. Dr. Pike opined that Claimant's capacity for work has been impaired by occupational pneumoconiosis, and that he has limited capacity for exercise, weight lifting, and walking. He also opined that due to the severity of COPD that it would be unlikely that Claimant would ever be considered for surgical evaluation and/or lobectomy. (DX 27).

[17] Dr. Pike also submitted a report to the Workers Compensation Fund on this same date. (DX 27).

January 19, 1999 – X-ray report by Dr. Gokhale: There is pulmonary hyperinflation, scattered areas of interstitial scarring throughout both lung fields, scattered post granulomatous calcifications, a prominent nodule in the right lower lobe which most likely represents a calcified granuloma, and a mild left basilar segmental atelectasis versus scarring. (DX 17).

April 30, 1999 – CT scan report by Dr. Sheperd: Correlation is made to prior CT performed 1/26/99. A highly calcified, less than 1 cm, granuloma in the superior segment of the right lower lobe. There has been no interval change. Some small scattered calcified granulomas elsewhere. There are changes of emphysema present which are much better appreciated on the thin resolution images. Impression: stable granulomas in the superior segment of the right lower lobe, and emphysema. (DX 17).

May 4, 1999 – Consultation report by Dr. Pike – Patient was previously tested and found to have a severe obstructive ventilatory defect. When he was seen in January he was noted to have a prominent right mid-lung nodule which was initially evaluated by CT scan and found to be consistent with a calcified benign appearance. Follow-up CT scan confirmed a calcified granuloma of less than 1 cm in the superior segment of the right lower lobe. Patient's chest x-ray has been stable. Patient's pulmonary symptoms are essentially stable (see PFT values charted above), he has wheezing and dyspnea with exertion, but he has not had evidence of a recent exacerbation. Oxygen saturation was 95%. Chest exam revealed diminished breath sounds but no wheezing. Assessment: underlying COPD. Previously diagnosed: severe obstructive ventilatory defect, preserved oxygenation, and coronary artery disease clinically stable. (DX 17).

May 21, 1999 – X-ray report by Dr. Tarver: No old film for comparison. Patient has emphasematous changes of the upper lobes and multiple small nodules scattered throughout his upper lobes. These could represent siliconic nodules; however, they are not quite small enough or dense enough, meaning the number per unit volume. There is also a 1 cm nodule seen in the right mid-lung which could represent a lung tumor. (DX 17).

September 9, 1999 – Consultation report by Dr. Pike – Patient claims to be clinically stable but his shortness of breath is markedly bothersome and prevents activity. PFT is consistent with a very severe obstructive ventilatory defect and the flow volume loop is also consistent with severe airway obstruction (see values charted above). Oxygen saturation on room air is 96%. Chest examination revealed diminished breath sounds and a few bibasilar crackles by no expiratory wheeze. Assessment: severe COPD with worsened pulmonary function. Compared to 1998, his FEV 1 has fallen from 1.17 liters to .88 liters. His dyspnea appears to be quite debilitating. (DX 17).

January 5, 2001 – Radiology report by Dr. Meyer – Lung parenchyma is unchanged since May 21, 1999. The lungs are hyperinflated. There is a relative paucity of markings in the apices consistent with emphysema. There are scattered dense nodular opacities which are clustered predominantly in the right upper lobe and to a lesser extent in the left upper lobe. In addition, there is a 1 cm nodule in the right mid-lung zone which is also stable. Impression: Emphysema;

occupational pneumoconiosis is felt to be unlikely as there is no background of fine nodularity. (DX 10).

January 21, 2001 – Radiology report by Dr. Farber – Scattered lung markings are seen diffusely. There are no acute infiltrates or effusions. (DX 11).

February 28, 2002 – CT scan report by Dr. Winer-Muram: There is a decrease in size of the left upper lobe mass-like opacity which extends to the left suprahilar region. Currently there is a residual irregular 2 cm nodule in the left upper lobe. There is also a 1.2 cm right lower lobe nodule which is similar to that seen on previous studies. Significant upper lobe emphysema was seen. Impression: Improvement in the opacity of the left upper lobe which may have represented pneumonia; irregular 2 cm opacity which is calcified and likely represents granulomatous changes which may be related to previous coal dust exposure; and significant emphysema. (DX 19).[18]

Smoking History

At the hearing, Claimant testified that he smoked between 1 and 1 ½ packs of cigarettes per day from 1953 until 1987. (Tr. 43-44). Dr. Farber reported a discontinued smoking history of one pack per day from approximately age 13 to age 50, or 35 pack-years. (DX 6). In a subsequent report, however, Dr. Farber reported a discontinued habit of 36 to 38 years at a rate of one pack per day, or approximately 37 pack-years. (DX 27). Dr. Goodman reported a discontinued smoking history of 1 ½ packs per day from age 16 until age 50 for a cumulative total of 70 pack-years. (DX 17).[19] Dr. Frome noted a 20 year history at ¾ pack per day, or 15 pack-years. (DX 26). Dr. Pike reported a smoking history of 30 years at a rate of 1 to 1 ½ packs per day, which ended in 1987, or 30 to 45 pack-years. (DX 27).

According to the evidence in the record, Claimant's smoking history falls somewhere between a minimum of 15 pack-years, according to Dr. Frome, to a maximum of 70 pack-years, based on the report by Dr. Goodman. (DX 15). I presume that the Claimant would not purposely overstate his smoking history, thereby presenting a possible detriment to his own case. As a result, I find that Claimant's testimony, which is generally supported by Drs. Pike and Farber, to be the most persuasive. Therefore, I find that Claimant smoked for 34 years at a rate of 1 to 1 ½ packs per day, or 34 to 51 pack-years. Thus, based on the midpoint, I find that Claimant has a 42.5 pack-year smoking history that ended in 1987.

DISCUSSION AND APPLICABLE LAW

Mr. Dobrzynski's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

[18] This report included a handwritten note from Dr. Dowdeswell dated March 14, 2002, stating that the chest x-rays and scans are compatible with pneumoconiosis.

[19] I note that a 1 ½ pack per day smoking history for 34 years actually equates to 51 pack-years.

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

(i) Has pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Is totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Compamy*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a

> miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), a multiple claim arising under the pre-amendment regulations at 20 C.F.R. § 725.309 (2000), the court reiterated that its previous decision in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) requires that the ALJ resolve two specific issues prior to finding a "material change" in a miner's condition: (1) whether the miner has presented evidence generated since the prior denial establishing an element of entitlement previously adjudicated against him; and (2) whether the newly submitted evidence differs "qualitatively" from evidence previously submitted. Specifically, the *Flynn* court held that "miners whose claims are governed by this Circuit's precedents must do more than satisfy the strict terms of the one-element test, but must also demonstrate that this change rests upon a qualitatively different evidentiary record." Even though this claim arises under the jurisdiction of the Fourth Circuit, I find the *Flynn* standard to be helpful in the determination of whether there has been a "material change" in condition.

Claimant's prior claim was denied after the Director determined that Claimant failed to establish any of the elements of entitlement. (DX 27). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, the presence of pneumoconiosis, that pneumoconiosis was caused by coal mine employment, or the existence of a totally disabling respiratory impairment caused by pneumoconiosis. If Claimant is able to prove any of these elements, then he will avoid having his subsequent claim denied on the basis of the prior denial.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in

the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

There is no evidence in the record to support a finding that Claimant suffered from complicated pneumoconiosis. While Dr. Cohen stated that the opacities in the right and left upper lobes "may" represent complicated pneumoconiosis, (CX 1), I do not find this a reasoned opinion due to the equivocal nature of his statement. In addition, at the hearing, counsel for the Claimant affirmed that only simple pneumoconiosis was at issue in this claim. (Tr. 24). Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of PFT studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. More weight may be accorded to the results of a recent ventilatory study over the results of an earlier study. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). The newly submitted PFT evidence includes four qualifying, pre-bronchodilator sets of values and two qualifying, post-bronchodilator sets of values. As a result, all of the newly submitted PFT evidence of record qualifies Claimant as totally disabled under subsection (b)(2)(i).

Dr. Branscomb, an internist, reviewed and invalidated each of these studies for a variety of reasons. On the other hand, Dr. Katzman, an internist and pulmonologist, specifically noted that the May 21, 1999 vents were acceptable, and Dr. Cohen, also an internist and pulmonologist, noted that the January 5, 2001 test was acceptable and reproducible. As a result, while Dr. Branscomb's invalidation of the September and October 1999 PFTs may be controlling, I do not find his invalidation of the May 1999 and January 2001 studies to be equally compelling. This is because more qualified physicians found these PFTs to be acceptable. Therefore, I find that the May 1999 and January 2001 PFTs are the most probative. As the preponderance of the newly submitted PFT evidence is qualifying under the regulatory tables found at Appendix B to Part 718, I find that Claimant has established total pulmonary disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of ABG studies meet the requirements listed in the tables found at Appendix C to Part 718. The only newly submitted ABG failed to produce pre-exercise values that meet the requirements of the tables found at Appendix C to Part 718, but it did produce qualifying post-exercise values. Because there is no reason to accord either the pre or post-exercise ABG evidence more weight, and both portions of this study were found to be technically acceptable by Dr. Katzman, I find that the ABG evidence is equally balanced. Therefore, I find that Claimant has failed to establish total disability by a preponderance of the evidence under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment as a control room operator typically involved sweeping, but he testified without contradiction that he was also required to repair belts, shovel coal, and climb 30 feet of stairs on a regular basis. (Tr. 28-33).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

The newly submitted medical narrative evidence includes reports from Drs. Farber, Morgan, Fino, Cohen, Dowdeswell, Diaz, and Pike finding Claimant to be totally disabled from a pulmonary standpoint. As these physicians based their opinions on Claimant's coal mine employment history and PFT and ABG results, I find them to be well-reasoned and well-documented, and thus, accord them probative weight. Next, I find that neither Dr. Goodman nor Dr. Meyer offered an opinion as to whether Claimant was totally disabled from a pulmonary or respiratory standpoint. Finally, while Dr. Branscomb's 2002 report and 2004 supplement stated that Claimant was totally disabled due to his pulmonary impairment, at the 2004 deposition, he admitted that he was unable to conclude that Claimant was unable to perform the exertion or rigors of his last coal mine employment from a pulmonary standpoint due to the fact that all of the PFTs of record were invalid. It is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports which were eight months apart rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in a earlier report and then, without explanation, found no total disability in a report issued five years later). Therefore, due to Dr. Branscomb's failure to explain his inconsistent conclusions with regard to total disability, I accord his opinion little weight.

I have found that all of the reasoned and documented newly submitted medical opinion evidence supports a conclusion to total pulmonary disability. And even though Dr. Branscomb's opinion was accorded little weight, I note that he did not rule out total disability, but instead, stated that he was unable to reach a conclusion. Therefore, I find that Claimant has proven total disability by a preponderance of the evidence under subsection (b)(2)(iv).

Considering the newly submitted evidence, Claimant has establish that he is totally disabled under both subsections (b)(2)(i) and (b)(2)(iv). Furthermore, even though Claimant has failed to prove total disability under subsection (b)(2)(ii), I find that the PFT and medical opinion evidence are more probative than the inconclusive ABG results. Therefore, after weighing all the newly submitted evidence of total disability under §718.204(b), I find that Claimant has satisfied this element of entitlement.

I also find that the newly submitted evidence is "qualitatively" different from the previously submitted medical evidence. First, the 1982 PFT was non-qualifying under the requirements of (b)(2)(i), and while the September 1998 PFT produced qualifying results, this study was rightfully invalidated by Dr. Branscomb due to a lack of tracings. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984)(a ventilatory study, a study which is not accompanied by three tracings may be discredited). Therefore, I find that the newly submitted PFT evidence is qualitatively different from the previously submitted studies.

Second, the 1982 ABG was non-qualifying under the requirements of (b)(2)(ii), as were the 1999 pre-exercise values. And even though the 1999 post-exercise values were qualifying, Dr. Cohen, an internist and pulmonologist, noted deficiencies with this portion of the study. As a result, I accord the 1999 post-exercise ABG results less weight. Therefore, even though both the previously submitted and newly submitted ABG evidence fail to prove total disability by a preponderance of the evidence, I find that the newly submitted ABG, while inconclusive, is substantially more supportive of total disability than the previously submitted studies.

Third, Dr. Frome's 1982 medical opinion did not find Claimant to be totally disabled from performing his previous job, but instead, simply identified restrictions based on his pulmonary capacity. Also, Dr. Farber's July 1999 report concluded that Claimant was totally disabled from a pulmonary perspective, which was identical to his conclusion in the newly submitted October 2001 report. However, while Dr. Farber may not have specifically found Claimant's condition to have worsened from 1999 to 2001, I note that Dr. Cohen, an internist and pulmonologist, stated that Claimant has had a clear progression of his pulmonary disease since 1999. Dr. Cohen explained that Claimant's FEV1 had declined from 48% of predicted in 1999 to 19% in 2001, and his ABG with exercise had fallen from 63 mmhg in 1999 to 55 mmhg in 2001.[20] Therefore, despite the fact that there are medical opinions diagnosing total disability in both the previously submitted and newly submitted evidentiary record, I find that based on the well-reasoned and well-documented report by Dr. Cohen, Claimant's pulmonary impairment has worsened since the denial of his previous claim**.**

Based on this analysis, I find that Claimant has demonstrated that he is totally disabled, which constitutes a material change in conditions as required under §725.309 (d). Therefore, Claimant's subsequent claim will not be denied on the basis of the prior denial, and thus, in order to receive benefits, he must satisfy the remaining requirements of §718, considering both the old and new evidence.

[20] Dr. Pike's September 1999 treatment report also notes this drop in Claimant's FEV1 value.

Pneumoconiosis

Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign

heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The record includes 14 interpretations of five chest x-rays.[21] Drs. Barger and Cole, radiologists and B-readers, interpreted the June 18, 1982 x-rays as negative for pneumoconiosis. There were no positive readings. Therefore, I find the June 18, 1982 chest x-ray to be negative for the disease.

Dr. Meyer, a radiologist and B-reader, Dr. Fino, a B-reader, and Dr. Branscomb interpreted the January 19, 1999 film as negative for pneumoconiosis. There were no positive readings. Therefore, I find the January 19, 1999 film to be negative for the disease.

Drs. Sargent and Wiot, radiologists and B-readers, interpreted the May 21, 1999 film as negative for pneumoconiosis. Dr. Morgan, a B-reader, read the film as category 0/1, which is non-qualifying under the regulations. Based on dually certified readings by Drs. Sargent and Wiot, I find that the May 21, 1999 chest x-ray is negative for pneumoconiosis.

Drs. Ahmed and Miller, radiologists and B-readers, and Drs. Gaziano and Cohen, B-readers, interpreted the January 5, 2001 film as positive for pneumoconiosis. There were no negative readings. Therefore, I find the January 21, 2001 x-ray to be positive for pneumoconiosis.

Dr. Cohen, a B-reader, interpreted the May 28, 2003 chest x-ray as positive for pneumoconiosis. Dr. Wiot interpreted the film as negative for the disease. According more weight to Dr. Wiot's dually certified reading, I find that the May 28, 2003 film is negative for the disease.

I have found that all of the chest x-ray evidence prior to 2001 is negative for pneumoconiosis. I have also determined that while the January 2001 film is positive and the May 2003 film is negative. Thus, four of the five x-rays of record are negative for pneumoconiosis. Furthermore, of the eight dually certified physicians to read these x-rays, six found them to be negative and only two found them to be positive for the disease. More probative, however, is the fact that the two most recent films are split as to whether Claimant suffers from pneumoconiosis. And while I may accord more weight to the most recent x-ray interpretations, in this case, I do not find the 18 months that separates the January 2001 and May 2003 films to be significant. In support, I note that Dr. Cohen has offered an identical classification for both of these x-rays. As a result, I have found that the most probative x-ray evidence of record is split, with dually credentialed interpreters on each side. Therefore, I find

[21] Included in the treatment notes are radiology reports by Drs. Scales, Pike, Gokhale, Tarver, Meyer, and Farber. With exception of Dr. Meyer. there is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

that the preponderance of the x-ray evidence, considered together under subsection (a)(1), is equally balanced, and thus, fails to establish the existence of pneumoconiosis.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. Section 718.305 is not applicable to claims filed after January 1, 1982. Also, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Finally, the presumption of § 718.304 does not apply because there is no evidence in the record to support a finding of complicated pneumoconiosis. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). On the other hand, an unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). For instance, a medical opinion based upon generalities, rather than specifically focusing upon the miner's condition, may be rejected. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

The record includes several CT scan interpretations. While these interpretations are included as part of the narrative reports, in the interest of clarity, I will first discuss all of the opinions concerning both the April 29, 1999 and the February 28, 2002 CT scan in order to reach a conclusion as to whether these studies are positive or negative for pneumoconiosis. I will then consider these CT scans in conjunction with the narrative medical opinions, and assign weight accordingly.

Concerning CT scans, at present, "[t]he clinical diagnosis and follow up of pneumoconiosis in most workforces at risk for pneumoconiosis are still based on the changes in the lung visible by standard X-ray techniques." *Consolidation Coal Co. v. Director, OWCP*, 294 F.3d, 885, 892 (7th Cir. 2002)(quoting Q.T. Pham, *Chest Radiography in the Diagnosis of Pneumoconiosis*, 5(5) INT. J. TUBERC. LUNG DIS. 478 (2001)). As a result, the Department of Labor has rejected the view that a CT-scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). CT scans, however, when evaluated by qualified experts are "important diagnostic tools that have resulted in major improvements in the assessment of occupational lung disease." *Consolidation Coal* 294 F.3d 892. Such qualified experts are generally "radiologists (some of whom may in addition be classified as B readers) who have specialized knowledge and have developed a certain expertise through years of training and experience interpreting this particular test." *Id*. at 894 (citing J.F. Wiot & O. Linton, *The Radiologist and Occupational Lung Disease*, 175(2), AM. J. ROENTGEN. 311 (2000)). A pulmonologist may have the knowledge, training and experience to review a CT scan and reliably discuss whether the test discloses the presence of pneumoconiosis, but a party must qualify an individual pulmonologist as such an expert. *Id*. Further, the results of a CT scan must be interpreted in conjunction with the occupational history, clinical examination, pulmonary function tests, x-rays, arterial blood gas tests and the reasoned opinions of all the experts and physicians. *Id*. at 892.

Drs. Goodman, Morgan, Meyer, Branscomb, Shepherd, and Pike reviewed the April 29, 1999 CT scan and provided interpretative opinions. Dr. Goodman, an internist and pulmonologist, identified interstitial changes consistent with centrilobular emphysema and calcified granuloma, but found no changes suggestive of CWP. Dr. Morgan, a B-reader, diagnosed centrilobular emphysema in the upper and mid zones and some in the lower zones with a few calcified granuloma, but found absolutely no evidence of nodules compatible with CWP. Dr. Meyer, a radiologist and B-reader, identified moderate to severe centrilobular emphysema and sequellae of prior granulomatous disease, but found no evidence of CWP. Dr. Branscomb, an internist, interpreted the CT scan as negative for pneumoconiosis. Dr. Sheperd found stable granulomas in the right lower lobe and emphysema, but provided no opinion as to the existence of pneumoconiosis. Dr. Pike stated that the CT scan revealed calcified granuloma in the superior right lower lobe, but he provided no opinion as to the existence of pneumoconiosis. I note that the record does not include credentials for Drs. Shepherd or Pike.

Based on the April 29, 1999 CT scan, Drs. Goodman, Morgan, Meyer, and Shepherd diagnosed centrilobular emphysema and calcified granuloma, with Dr. Pike affirming only the existence of calcified granuloma. In addition, Drs. Goodman, Morgan, Meyer, and Branscomb concluded that this scan revealed no evidence of pneumoconiosis. Drs. Pike and Shepherd, however, did not provide an opinion as to whether the scan showed any signs of

pneumoconiosis. In addition, there are no opinions interpreting this study as positive. Therefore, I find that by a preponderance of the evidence, while the April 29, 1999 CT scan is positive for centrilobular emphysema and calcified granuloma, it is negative for pneumoconiosis.

Drs. Fino, Meyer, Branscomb, Cohen, Winer-Muram, and Dowdswell reviewed the February 28, 2002 CT scan and provided interpretive opinions. Dr. Fino, an internist, pulmonologist, and B-reader, identified an area of infiltrate with questionable bronchiectasis in the upper left lobe, which he dismissed as possible pneumonia or granulomatous disease, and he concluded that there were no changes consistent with pneumoconiosis. Dr. Meyer, a radiologist and B-reader, diagnosed moderate to severe bilateral emphysema and sequellae of prior granulomatous disease, but found no evidence of CWP. Dr. Branscomb, an internist, interpreted the CT scan as negative for pneumoconiosis. Dr. Winer-Muram identified a left upper lobe opacity, which may have represented pneumonia; an irregular opacity, which is calcified and likely represents granulomatous changes and "may" be related to previous coal dust exposure; and significant emphysema. Written at the bottom of Dr. Winer-Muram's report is a note by Dr. Dowdswell which states that the chest x-rays and scans are compatible with pneumoconiosis. Dr. Cohen, an internist, pulmonologist, and B-reader, identified diffuse changes of emphysema present in both lungs, round irregular opacities predominant in the upper lobes, large opacities in the left upper lobe and right lower lobe, and a round calcified opacity in the right lower lobe superior segment. Citing several positive CT scan interpretations, Dr. Cohen diagnosed clinical pneumoconiosis. I note that the record does not include credential for Drs. Winer-Muram and Dowdeswell.

Based on the February 28, 2002 CT scan, Drs. Fino, Meyer, Cohen, and Winer-Muram diagnosed emphysema. Also, Drs. Fino, Meyer, Cohen, and Winer-Muram identified granulomatous changes. However, I find Dr. Winer-Muram opinion – these changes "may" be related to previous coal dust exposure – to be equivocal, and accord it less weight. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988). Dr. Cohen also identified a number of opacities in his review of the scan, but he provided no etiology for these findings. In his summary, however, Dr. Cohen stated that he based his legal pneumoconiosis finding, in part, on the positive CT scan interpretations he considered. But with exception of Dr. Winer-Muram's equivocal report, the only other positive interpretation Dr. Cohen considered was Dr. Dowdeswell's handwritten note diagnosing pneumoconiosis based on both x-ray evidence and CT scan evidence. In fact, there is little support that Dr. Dowdeswell actually reviewed the films, but simply reached his conclusion based on Dr. Winer-Muram's report.

In the end, I find that the preponderance of the evidence supports a finding that the February 28, 2002 CT scan is positive for emphysema and granulomatous changes, but the cause of these changes are uncertain. The only radiologist to interpret the scan found it to be negative for pneumoconiosis, while the two pulmonologists, who are also B-readers, were split as to whether it represented the disease. Therefore, I find that the February 28, 2002 CT scan is inconclusive for the existence of pneumoconiosis.

The evidentiary record contains eleven physician opinions addressing the existence or absence of pneumoconiosis. Dr. Frome, examined Claimant and diagnosed chronic bronchitis by history, but found no evidence of pneumoconiosis. He also opined that coal dust exposure would

contribute to and aggravate Claimant's chronic bronchitis. I find that Dr. Frome's opinion is entitled to limited weight. First, even though he considered objective evidence in reaching his conclusion, his diagnosis of chronic bronchitis was based only on history, which does not qualify as an objective standard as required by subsection (a)(4). Second, I do not find his opinion that coal dust exposure would contribute to or aggravate Claimant's chronic bronchitis to be the same as concluding that Claimant's chronic bronchitis was "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Third, a medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). *See also Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984) (more recent reports are entitled to more weight than reports dated eight years earlier). Dr. Frome's report is more than 17 years older than the next most remote medical opinion of record. As a result, even if I had found that Dr. Frome's 1982 report to be a well-reasoned and well-documented diagnosis of legal pneumoconiosis, and thus entitled to probative weight, its weight would still be diminished based solely on its remoteness. Therefore, I accord it less weight than the newly submitted evidence for the purpose of determining whether Claimant suffers from pneumoconiosis under subsection (a)(4).

Dr. Pike submitted treatment reports on September 28, 1998, May 4, 1999, and September 9, 1999. In his initial report he considered accurate employment and smoking histories, conducted a physical examination, an x-ray, a PFT, and an ABG. In his subsequent reports he also considered additional clinical examinations, x-ray, PFT, and ABG studies, and a CT scan. Only in 1998 did Dr. Pike diagnose pneumoconiosis, and in this report he stated that his opinion was based solely on the x-ray evidence and Claimant's history of coal mine employment. When a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc*., 8 B.L.R. 1-405 (1985). Therefore, Dr. Pike's clinical pneumoconiosis diagnosis does not constitute a reasoned opinion for purposes of proving the existence of the disease under subsection (a)(4).

Dr. Pike diagnosed COPD in each of his reports, but at no time did he attribute this condition to coal dust exposure or any other cause. In 1998 he opined that based on the PFT, Claimant's COPD included elements suggestive of emphysema and chronic bronchitis. In the May 1999 report he stated that the objective evidence revealed underlying COPD. Finally, in the September 1999 report Dr. Pike concluded that Claimant suffered from COPD with worsening pulmonary function. While Dr. Pike's opinion is adequately supported by the objective evidence he considered, and thus, well-documented and well-reasoned, I find that his opinion is silent as to the issue of whether Claimant's COPD constitutes legal pneumoconiosis. Therefore, I accord his opinion no weight in the analysis under subsection (a)(4).

Dr. Farber examined Claimant on July 21, 1999, and again on October 26, 2001. Dr. Farber considered accurate coal mine employment and smoking histories. He also conducted separate physical examinations, PFTs and ABG studies for each report, and considered an x-ray in conjunction with the 1999 report. On both occasions, Dr. Farber diagnosed COPD and IPF caused by smoking and coal dust exposure, but he failed to provided any explanation as to why

he did not attribute these conditions solely to cigarette smoking. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). As a result, while I find his COPD diagnosis to be adequately based on the objective evidence he considered, and thus, well-documented, I find that he has failed to provide a sufficient explanation as to how the objective evidence supports a finding of legal pneumoconiosis. Therefore, I find Dr. Farber's reports to be insufficiently well-reasoned and accord them little weight.

Dr. Goodman, an internist and pulmonologist, submitted a report on October 26, 1999, and was deposed on March 11, 2002. In the 1999 report Dr. Goodman considered an accurate employment history, a 70 pack-year smoking history, a physical examination, a PFT, an ABG study, and some of Claimant's treatment records. Dr. Goodman diagnosed chronic obstructive lung disease and chronic bronchitis, but he also stated that based on exposure to coal dust, Claimant "certainly qualifies for his prior diagnosis of black lung."

Dr. Goodman's 2002 deposition responses were based on the evidence he considered in his 1999 report, but he also considered the January 19, 1999 x-ray, the April 29, 1999 CT scan, and the May 21, 1999 PFT. Based on this evidence, Dr. Goodman concluded that the x-rays revealed hyperinflation consistent with COPD, the CT scan showed interstitial changes consistent with centrilobular emphysema, and calcified granuloma, and the PFT values were compatible with reversible airways disease associated with severe obstructive disease. Dr. Goodman also ruled out CWP based on the x-ray and CT scan findings, and opined that COPD with centrilobular emphysema is "almost always a consequence of cigarette smoking."

It is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports which were eight months apart rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in a earlier report and then, without explanation, found no total disability in a report issued five years later). Also, a physician's opinion is less probative where it is based on an inaccurate smoking history. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993). Furthermore, a medical opinion based upon generalities, rather than specifically focusing upon the miner's condition, may be rejected. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985).

While there is an apparent inconsistency between Dr. Goodman's 1999 finding that Claimant "certainly qualifies for his prior diagnosis of black lung," and his 2002 conclusion that he did not find any evidence of CWP, I find that his deposition testimony was sufficient to clear up this contradiction. He explained that the statement in the 1999 report was based on Claimant's history form and subjective opinion that he suffered from black lung, but based on the objective testing, Dr. Goodman found no evidence of CWP. As a result, I do not find that the apparent inconsistency between the report and deposition diminishes the weight accorded to Dr.

Goodman's ultimate opinion. Therefore, I find that Dr. Goodman's finding of no clinical pneumoconiosis is well-reasoned and well-documented, and accord his opinion probative weight.

On the other hand, due to a calculation error, Dr. Goodman considered a 70-pack year smoking history in arriving at his conclusion that there was nothing in Claimant's presentation, symptoms, or ventilatrory studies that would be inconsistent with COPD caused by cigarette smoking alone. This smoking history exceeds my finding by more than 20 years, and I find this inaccuracy sufficient to undermine the weight to be accorded to Dr. Goodman's opinion. In addition, I find that Dr. Goodman's statement – COPD with centrilobular emphysema is "almost always a consequence of cigarette smoking" – is a generality, and does not specifically focus on Claimant's condition. In addition, I do not find Dr. Goodman's opinion – there is nothing in Claimant's history or his ventilatory studies that would be inconsistent with COPD caused by cigarette smoking alone – to be equivalent to an explanation as to why Claimant's COPD was not caused, in part, by coal dust exposure. Based on these factors, I find that while Dr. Goodman's opinions are sufficiently well-documented, he has failed to offer sufficient support for his finding of no legal pneumoconiosis, and thus, his report is poorly reasoned. Therefore, despite his advanced credentials, I accord Dr. Goodman's opinions little weight.

Dr. Morgan, a B-reader, submitted a medical evidence review on January 6, 2002, and was deposed on March 14, 2002. In addition to his review of most of the reports contained in the evidentiary record, Dr. Morgan also interpreted the January 19, 1999 x-ray and the April 29, 1000 CT scan. Concerning clinical pneumoconiosis, Dr. Morgan opined that based on the CT scans and x-rays, that there was absolutely no evidence that Claimant suffered from CWP. He explained that the emphysema and t opacities revealed in these studies were of the type frequently seen in patients who have asbestosis or other occupationally related lung disease, but that they were not the type of opacities seen in silicosis or CWP. As Dr. Morgan's opinion was adequately supported by the objective evidence he considered, I find his opinion as to the presence of clinical pneumoconiosis to be well-reasoned and well-documented. Therefore, bolstered by his credentials as a B-reader, I accord Dr. Morgan's opinion as to the existence of clinical pneumoconiosis substantial probative weight.

Turning to legal pneumoconiosis, Dr. Morgan opined that there was no doubt that Claimant suffered from severe airways obstruction, but found no evidence of any restrictive impairment. In addition, while he affirmed Dr. Farber's diagnosis of COPD, he disagreed with his identification of idiopathic pulmonary fibrosis. Dr. Morgan explained in detail that the 1982 pulmonary function testing, when compared to that conducted in the late 1990's, and considered in conjunction with the x-ray and CT scan evidence, revealed a pulmonary regression consistent with emphysema and COPD caused by cigarette smoking. Also, Dr. Morgan justified cigarette smoking as the cause of Claimant's COPD by noting that Claimant's FEV 1 has continued to decline since his retirement and the resulting absence of silicosis. Dr. Morgan further noted that there was nothing unusual about Claimant's pattern of pulmonary impairment that would lead him to believe that it was the result of anything other than cigarette smoking. As Dr. Morgan's opinion is adequately supported by the objective evidence he considered, I find his opinion as to the presence of legal pneumoconiosis to be well-reasoned and well-documented. Therefore, I accord Dr. Morgan's opinion as to the existence of legal pneumoconiosis probative weight.

Dr. Meyer, a radiologist and B-reader, submitted interpretations of the April 29, 1999 and February 28, 2002 CT scans and the January 19, 1999 chest x-ray. At his 2002 deposition he opined that the 1999 CT scan was consistent with his interpretation of the 1999 chest x-ray. Considering all three of these studies, Dr. Meyer concluded that there was nothing to suggest changes consistent with CWP or any other coal mine dust induced pneumoconiosis. As discussed above, I have determined that the January 19, 1999 chest x-ray and the April 29, 1999 CT scans are negative. In addition, while I have not found the February 28, 2002 CT scan to be negative for pneumoconiosis, I have also not determined it to be positive. As a result, Dr. Meyer's opinion is not inconsistent with my previous findings, and since it is sufficiently based on the objective evidence before him, I find his conclusions to be well-reasoned and well-documented. Therefore, bolstered by his advanced credentials, I accord Dr. Meyer's opinion substantial probative weight.

Dr. Fino, an internist, pulmonologist, and B-reader, submitted a medical evidence review and interpreted the January 19, 1999 chest x-ray and the April 29, 1999 and February 28, 2002 CT scans. Based on the PFT and ABG evidence, Dr. Fino opined that Claimant was totally disabled due to his respiratory impairment. In addition, he concluded that this impairment was due to smoking, and there was insufficient evidence to justify a diagnosis of either clinical or legal pneumoconiosis. Dr. Fino explained that the CT scan evidence demonstrated no changes consistent with pneumoconiosis. Also, in support of his finding of no legal pneumoconiosis, Dr. Fino explained that since Claimant stopped working in 1980 and the 1982 pulmonary testing revealed no evidence of any ventilatory impairment or oxygen transfer abnormality, and since Claimant continued to smoke until the mid 1980's, that the decrease in FEV1 as demonstrated by the 1998 pulmonary testing revealed a dramatic drop that is inconsistent with a coal dust related pulmonary condition, but is consistent with smoking. As Dr. Fino's opinion was adequately supported by the objective evidence he considered, I find his opinions as to the absence of either clinical or legal pneumoconiosis to be well-reasoned and well-documented. Therefore, bolstered by his advanced credentials, I accord Dr. Fino's opinions substantial probative weight.

Dr. Branscomb, an internist, submitted a December 9, 2002 medical evidence review, a February 6, 2004 supplemental report, and was deposed on March 15, 2004. In addition to the medical evidence of record, Dr. Branscomb based his conclusions on accurate coal mine employment[22] and smoking[23] histories, and his own interpretations of the January 19, 1999 chest x-ray and the April 29, 1999 and February 28, 2002 CT scans. Concerning clinical pneumoconiosis, Dr. Branscomb opined that the objective evidence of record did not support a diagnosis of CWP. As Dr. Branscomb's opinion is adequately supported by the objective evidence he considered, I find his opinion as to the presence of clinical pneumoconiosis to be well-reasoned and well-documented. Therefore, I accord probative weight to Dr. Branscomb's opinion as to the existence of clinical pneumoconiosis.

Even though he found all of the PFTs after 1982 to be invalid, considering the contours of the available curves in conjunction with the ABG studies, Dr. Branscomb opined that the

[22] Dr. Branscomb specifically noted that only eight years of Claimant's coal mine employment were underground at the face.

[23] While Dr. Branscomb's 2002 report appears to rely on a 70 pack-year history, he makes it clear in the 2004 submissions that his opinions were based on a 35 to 50 pack-year smoking history.

evidence was sufficient to find that Claimant suffered from a severe, partly reversible, obstructive airways disease. Dr. Branscomb also opined that this condition did not constitute legal pneumoconiosis, but instead was caused solely by cigarette smoking. He explained that Claimant's obstructive pulmonary disease was typical of the COPD found in patients with severe smoking habits, especially those who have GERD. In addition, noting Claimant's eight-year exposure to coal dust, he stated that the sequence of Claimant's retirement in 1980, combined with his worsening pulmonary condition, was not consistent with obstruction secondary to coal dust exposure, but instead, was characteristic of cigarette smoking. As Dr. Branscomb's opinion is adequately supported by the objective evidence he considered, I find his opinion as to the presence of legal pneumoconiosis to be well-reasoned and well-documented. Therefore, bolstered by his credentials, I accord substantial probative weight to Dr. Branscomb's opinion as to the absence of legal pneumoconiosis.

In addition to most of the medical evidence in the record, Dr. Cohen, an internist, pulmonologist, and B-reader, based his report on accurate smoking and coal mine employment histories, his independent review of the May 28, 2003 and January 5, 2001 chest x-rays, and the February 28, 2002 CT scan. Dr. Cohen diagnosed clinical pneumoconiosis based on several of the positive x-ray and CT scan interpretations. I note that Dr. Cohen's positive interpretation of the May 28, 2003 x-ray was reread to be negative by a higher credentialed interpreter. Also, I find that by simply listing the x-rays and CT scan interpretations he reviewed, and then stating that based on "several" of these studies he diagnosed clinical pneumoconiosis, it is not totally clear as to which evidence he specifically relied upon or why he preferred one interpretation over another. However, since I did not find the January 5, 2001 chest x-ray or the February 28, 2002 CT scan to be negative, I find that the evidence he considered generally supports his conclusions. Therefore, bolstered by his credentials as a B-reader, I accord Dr. Cohen's well-reasoned and well-documented opinion as to the existence of clinical pneumoconiosis probative weight.

Turning to legal pneumoconiosis, Dr. Cohen opined that Claimant's COPD was substantially related to his coal mine employment. Dr. Cohen explained that it was very unlikely that the reduction in PFT values between 1982 and 1999, 12 years after Claimant quit smoking and 17 years after he retired from coal mine employment, was caused by the seven years of continued smoking alone. Also, he found that the overall PFTs demonstrated a progressively severe obstructive defect caused by coal dust and smoking that was most likely present in 1982 based on the FEV 1 that was at the lower limit of normal, and then progressed over the next 20 years. Beginning in 1999, the ABG studies showed significant gas exchange abnormalities which he concluded was due more to coal dust exposure than tobacco smoke. As the objective evidence he considered adequately supports his conclusions, I find Dr. Cohen's opinion as to the presence of legal pneumoconiosis to be well-reasoned and well-documented. Therefore, bolstered by his credentials as an internist and pulmonologist, I accord substantial probative weight to Dr. Cohen's conclusions as to the existence of legal pneumoconiosis.

Dr. Dowdswell submitted a letter stating that he had been Claimant's treating physician for three years. I note, however, that other than a handwritten note at the bottom of Dr. Winer-Muram's February 28, 2002 CT scan report, there is no evidence in the record to confirm the extent or nature of Dr. Dowdswell's treatment of Claimant. Based on a January 2, 2004 PFT, a 2004 chest x-ray, and seven prior PFTs that he personally conducted, Dr. Dowdswell opined that

Claimant suffers from severe obstructive lung disease caused by both cigarette smoking and CWP. In addition, he explained that the x-ray abnormalities, PFT results, and a well-recognized association between coal dust exposure and obstructive lung disease makes it "likely" that Claimant's occupational exposure contributed to his progressive lung disease.

There are a number of deficiencies with Dr. Dowdswell's letter that substantially undermine the weight to be accorded to his opinion. First, there is no mention in the record of any PFTs personally conducted by Dr. Dowdswell, nor does he specifically list any of the PFTs of record as a basis for his opinion. Second, there is no 2004 PFT or ABG evidence in the record. Third, the well-recognized association between coal dust exposure and obstructive lung disease that he cites as a basis for his conclusion is clearly a generalization and does not specifically focus on Claimant's particular condition. *Knizer*, 8 B.L.R. 1-5. Fourth, I find his opinion that it was "likely" that Claimant's occupational exposure contributed to his progressive lung disease to be equivocal. *Justice*, 11 B.L.R. 1-91. Based on these factors, I find that Dr. Dowdswell's opinion is insufficiently well-reasoned and well-documented to prove the existence of pneumoconiosis under subsection (a)(4). Therefore, despite his status as Claimant's treating physician, I accord Dr. Dowdswell's opinion little weight.

Dr. Diaz, an internist and pulmonologist, submitted a letter in January 2004. Based on the January 5, 2001 PFT report, and all of the medical evidence reviews of record, Dr. Diaz opined that Claimant suffered from severe COPD in the form of emphysema, which was caused by a combination of coal dust exposure and cigarette smoking. Dr. Diaz explained that a 34 to 51 pack-year smoking history qualifies as a "moderate" smoking history, and in the setting of this moderate smoking history, coal dust exposure was a factor in the development of Claimant's very severe airflow obstruction. As the objective evidence he considered adequately supports Dr. Diaz's conclusions, I find his opinion as to the presence of legal pneumoconiosis to be well-reasoned and well-documented. Therefore, bolstered by his credentials as an internist and pulmonologist, I accord Dr. Diaz's opinion as to the existence of legal pneumoconiosis substantial probative weight.

To summarize my determinations concerning the clinical pneumoconiosis findings contained in the medical opinion evidence, I have found Dr. Pike's opinion to be entitled to no weight; Dr. Dowdswell's opinion to be entitled to little weight; Drs. Goodman, Branscomb, and Cohen's opinion to be entitled to probative weight; and Drs. Morgan, Meyer, and Fino's opinions to be entitled to substantial probative weight. As all of the opinions that were accorded substantial probative weight found that Claimant does not suffer from clinical pneumoconiosis, I find that the preponderance of the medical opinion evidence fails to prove the existence of clinical pneumoconiosis.

The determination of whether Claimant suffers from legal pneumoconiosis presents a much closer call. I have accorded the opinions by Drs. Frome, Farber, Goodman, and Dowdswell little weight, and I have found that Dr. Morgan's opinion is entitled to probative weight. The most probative opinions of record, however, are those by Drs. Fino and Branscomb, finding that Claimant does not suffer from legal pneumoconiosis, and those by Drs. Cohen and Diaz, finding that he does suffer from legal pneumoconiosis. As a result, I have accorded all four of these physicians substantial probative weight.

Dr. Diaz criticized Dr. Branscomb's initial consideration of a 70 pack-year smoking history. However, as noted above, Dr. Branscomb adequately addressed this mistake in his subsequent report and deposition, so I do not find Dr. Diaz's criticism to be enough to tip the scales. In addition, Dr. Cohen noted that while Dr. Branscomb relied on the fact that Claimant's condition worsened over the 19 years since leaving the mines, he failed to mention that this reduction in respiratory function took place 12 years after Claimant quit smoking. Dr. Cohen's statement is technically correct, in that Dr. Branscomb did not specifically explain what impact 12 years of non-smoking had on Claimant's pulmonary condition, but as Dr. Branscomb accurately noted that Claimant quit smoking in 1987, I do not find Dr. Cohen's arguments sufficient to diminish the weight accorded to Dr. Branscomb's opinion. Next, Dr. Branscomb disagreed with Dr. Diaz's characterization of a 34 to 51 pack-year smoking history as "moderate." While I find this criticism convincing, especially considering the weight Dr. Diaz accorded to this "moderate" smoking history in reaching his legal pneumoconiosis conclusion, I do not believe that the label "moderate" or "heavy" has any particular importance as long as the physician considered an accurate amount of smoking history.

The ultimate issue in this case is, as stated by Dr. Diaz, whether the progression of emphysema after removal from the coal mines rules out coal dust as a contributing cause to Claimant's COPD. Drs. Branscomb and Fino believe that it does, and Drs. Cohen and Diaz feel that it does not. Based solely on Claimant's extensive smoking history juxtaposed against the fact that only 8 of the 13 years he spent in the mines was underground, at the face, I am inclined to agree with Drs. Branscomb and Fino. However, to so decide would be substituting my judgment for that of the medical experts. Therefore, as I find the evidence for and against the existence of legal pneumoconiosis to be equally balanced, and since the burden is on the Claimant to prove that he suffers from the disease, I find that the preponderance of the newly submitted evidence under subsection (a)(4) does not support a finding of legal pneumoconiosis.[24]

Reviewing the evidence considered under § 718.202(a) as a whole, I find that Claimant has not established that he suffers from pneumoconiosis pursuant to subsection (a)(1-4). Therefore, considering all of the newly submitted and prior medical evidence, I find that Claimant has failed to prove that he suffers from pneumoconiosis under § 718.202 (a) by a preponderance of the evidence.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether Miner's total disability was caused by Miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or

[24] Even if I were to accord Dr. Branscomb's opinion only probative weight due on his consideration of PFT evidence he found to be invalid, and his lack of pulmonologist credentials; considering only the substantially probative opinions by Drs. Fino, Cohen, and Diaz, my ultimate opinion as to the existence of legal pneumoconiosis would remain unchanged. I reach this conclusion despite the numerical superiority of Drs. Cohen and Diaz's combined reports because I find that they are insufficient to undermine the weight I have accorded to Dr. Fino's well-reasoned and well-documented opinion. Therefore, even without consideration of Dr. Branscomb's opinion, I find that the evidence for and against the existence of legal pneumoconiosis remains balanced, and that Claimant has failed to prove the existence of legal pneumoconiosis by a preponderance of the evidence.

pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

While I have found that Claimant is totally disabled due to his COPD, as with the §718.202(a)(4) analysis above, I find that the evidence for and against whether coal dust was a substantially contributing cause of this COPD is equally balanced. Again, the burden is on Claimant to prove this element of entitlement by a preponderance of the evidence. Therefore, I find that since the expert opinions are equally balanced, Claimant has failed to prove by a preponderance of the evidence that his totally disabling COPD was caused, in part, by pneumoconiosis.

Entitlement

The Claimant, Mr. Dobrzynski, has establish a material change in conditions sufficient to meet the statutory requirements of § 725.309(d), but has failed to prove that he suffered from pneumoconiosis, or that his total disability was due to pneumoconiosis. Therefore, Mr. Dobrzynski is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Edward Dobrzynski for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).